Testimony of

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on

THIRD PARTY BILLING

before the

HOUSE COMMERCE COMMITTEE, SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

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Chairman Upton, Representative Klink, distinguished Subcommittee members, thank you for inviting us to discuss our efforts to address concerns with third party billing agents. This is an area of growing concern, and we greatly appreciate this subcommittee's interest and support, as well as the efforts of the General Accounting Office and HHS Inspector General.

Third party billing companies who operate ethically can provide a valuable service to providers and suppliers who seek out their help in submitting claims correctly and efficiently. These firms vary greatly, performing a wide variety of services from simply formatting claims for submission to Medicare and private insurance companies to managing the entire "business end" of provider practices.

Improper third party billing practices can pose a significant threat to Medicare. Under current regulations, we review these arrangements only when new Medicare providers or suppliers ask that their payments be made to an agent. These reviews have led to an increase in the number of third party billing contracts that are in compliance with existing laws and regulations.

However, when billing companies assist in preparing bills or coding, but do not actually receive payment, they generally are not regulated. Billing arrangements for providers who entered the program before 1996 are not reviewed, and our overall ability to monitor third party billing practices is quite limited. Problems identified by us, our HHS Inspector General and General Accounting Office colleagues, and others make clear that we need to do more.

We are working to strengthen the available safeguards to better protect the Medicare Trust Fund from waste, fraud and abuse. We are developing new enrollment regulations and a new

enrollment database for all providers. This database will gather information on third-party billing companies. The new enrollment regulations will require providers to periodically update information, including their billing arrangements.

And, in publishing the provider enrollment regulation proposal this spring, we intend to invite public comments on how to address challenges in better oversight of third party billing companies. For example, the costs and benefits of collecting additional information, changing electronic claims submission standards, setting and enforcing regulatory standards, overseeing private contracts, and other possible risk mitigation strategies must be weighed. There also may be unintended consequences and marketplace responses to any actions that should be carefully assessed and considered.

Background

Third party billing companies can take on many different forms, structures, operations, functions and relationships with providers. Billing companies vary significantly in both the size and reach of their organizations and functions, from small "mom and pop" organizations who only facilitate the electronic submission of claims to large business organizations providing coding, claims submission and consulting services. As the U.S. Department of Health and Human Services Office of Inspector General noted,

> "It is important to note the tremendous variation among billing companies in terms of the types of services and the manner in which these services are provided to their respective clients. For example, some billing companies code the bills for their provider clients, while others only process bills that have already been coded by the provider.
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> "Some billing companies offer a spectrum of management services, including accounts receivable management and bad debt collections, while others offer only one or none of these services." (HHS OIG, "Compliance Program Guidance for Third-Party Medical Billing Companies, page 3.)

False Claims

Billing companies that engage in behavior that gives rise to false claims can be held accountable under the False Claims Act. One such case was brought through qui tam or "whistleblower" lawsuits. The firm, Emergency Physicians Billing Service, had promised its clients it would increase their reimbursements by 10 to 25 percent. Unfortunately, it did so by "upcoding," or filing claims for a higher level of service than was actually delivered. Reassignment violations and misrepresentations on Medicare enrollment applications were also identified.

In a settlement agreement last fall with the federal government and 28 individual states, the firm and its owner, and J. D. McKean, Jr., M.D., agreed to pay $15.5 million. In addition, McKean is excluded for 15 years from participation in any federal health care program. The firm has entered into a comprehensive Corporate Integrity Agreement with the Inspector General. And the federal government is negotiating additional settlements with approximately 25 emergency physician groups that were clients of the firm.

This case serves as a national example of improper billing perpetrated by third party billers. We,

along with staff from five Medicare contractors, participated in this investigation, performing data analysis directed at detecting the improper billing, suspending Medicare payment, and calculating the losses to the program.

In fact, one of the contractor employees received a commendation for their exemplary performance during the investigation from the Department of Justice.

Current Oversight

Our current ability to detect such abuses is limited. Medicare does not have a direct business relationship with such entities, and the only oversight authority we have is to review arrangements for new fee-for-service providers who have entered the Medicare program since 1996 and requested that their payments be made directly to a third party billing agent.

Medicare claims processing contractors conduct reviews for these requests to ensure compliance with the statutory requirement that the provider's compensation to such an agent not be related in any way to the dollar amounts billed or collected. These reviews have led to an increasing number of such agreements coming into compliance with the statute and regulations. As the health care and billing communities have become more aware of these requirements and our enforcement of them, we see more contracts expressly containing language supporting our requirements.

However, thorough assurance of compliance with the law is hampered by:

- the resource-intensive process for reviewing lengthy, complicated legal documents;
- the capacity of contractors to accurately and fully understand such documents;
- variability in the nature and scope of agreements and the complicated corporate structure reflected in such agreements, where it is not unusual to find a number of subcontractors involved in various functions;
- lack of penalties for failure to inform Medicare when such agreements change; and
- the limited number of providers and suppliers required to submit such information.

Our ability to identify when third party billers have been involved in submitting claims is also limited. Paper claims include a space for listing the "source" or "preparer" of the claim. And electronic claims differentiate whether the claim was sent by a third party agent or directly by a provider. However, we are not able to identify all entities that may have had a role in processing and filing a claim.

For example, if a third party billing company coded the claim and sent it to a clearinghouse that formatted the claim for electronic submission to the Medicare program, only the clearinghouse information would be evident on the claim.

New Enrollment Process

We are taking steps to improve our oversight of third party billing arrangements. We plan to issue this Spring a proposed rule that would, among other things, require periodic verification of

provider enrollment data and reporting of changes in third party billing arrangements. Once the proposed rule is finalized, we will begin an "enrollment clean up" process and require providers and suppliers to confirm and update their information, including information on third party billing arrangements.

We also are developing a new national database, the Provider Enrollment, Chain and Ownership System, that will include extensive information on providers, including information on providers' billing arrangements and any reassignment of benefits. It also will include information on chain ownership and related organization information, which is essential because it allows us to identify when a provider or supplier is part of a larger organization, and to view the entire line of business. This will also allow a local contractor to view national data about an individual or entity rather than simply the data that appears on a local provider file. And it will better identify providers and suppliers who have been denied privileges, or subject to revocations or exclusions.

Even with this new system and our enrollment "clean-up" process, outstanding issues remain. These include:

- identifying common ownership among billing entities or "linking" agencies that might operate in different jurisdictions;
- regulating billing agents to ensure adherence to professional standards; and
- our lack of information on third party billers who do not negotiate checks or submit claims directly to the program.

We are seeking to answer many of these questions through comments to proposed regulations.

In our proposed provider enrollment regulation, we will solicit comments on several approaches to better oversight of third party billing agents. Among the issues we are considering in regulation billing agents:

- Should we register billing companies, and/or set standards for them?
- Would we need additional legislative authority to do so?
- Should such standards apply only to entities that actually submit claims and receive negotiated checks on behalf of providers?
- Should such standards apply to all entities that might advise, consult, prepare, support, staff, or otherwise influence the selection of codes and claims to be submitted to the Medicare program?
- How should such standards reflect the diversity in capability, organization, mission, functions, and relationships in the industry?
- How would we enforce such standards?
- What staffing and skill set needs would we require in order to ensure billing companies met standards and agreements were properly executed?

- How should claims properly reflect the preparer's identifying information? What if there are multiple preparers or submitters?
- To what extent would providers, suppliers, and physicians support Medicare regulation of their business contracts and partners?
- To what extent is surveillance and assessment of billing patterns a better approach to ensure compliance than registration or standard setting?
- What information would be needed to accurately group claims handled by a common third party billing company?
- If Medicare were to regulate business arrangements with third party billing companies, what impact would such regulation have on the private sector and the arrangements between providers and third party billers in submitting claims to private insurance companies and, overall, would those effects be positive or negative?

Answers to these questions are necessary before we can proceed in taking further action to address third party billing concerns.

Education Efforts

In the meantime, we will increase our efforts to educate providers and billing agents about legal requirements for their relationships, as well as how to file claims correctly. One of the task orders we have for our special new program integrity contractors specifically focuses on developing educational strategies for third party billers.

We want to build on the success we achieved in working to educate billing agents about how to be prepared for the Year 2000 information system challenge. These efforts helped to ensure that these billers were aware of our format requirements, Y2K compliance standards, and testing standards. Our claims processing contractors aggressively pursued testing with these submitters to assure their systems were ready for Y2K. And these billers helped us in setting up a major conference to bring together these organizations and Medicare contractors to discuss testing and implementation strategies and timetables.

We intend to pursue similar avenues of education on other issues of importance to third party billing initiatives. For example, we have already contacted a major association to invite key billers to participate in education sessions for the new outpatient prospective payment system. We will continue dialogue with these organizations on future, significant changes to Medicare's claims processing systems. And these relationships should help contribute to a climate of cooperation in all our efforts, including those related to program integrity.

CONCLUSION

We are making some progress in addressing concerns about third party billing. Our new provider enrollment system and database will help us make additional progress. However, we clearly have much more to do to fully protect program integrity in this area. We are committed to working with providers, billing agents, our IG and GAO colleagues, and Congress as we proceed. I thank you again for holding this hearing, and I am happy to answer your questions.

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